

Myths, Legends and Paradox- the treatment of medical evidence in the UK asylum system

Dr Juliet Cohen
Head of Doctors
2.10.2015



freedomfromtorture.org

Medical Foundation for the Care of Victims of Torture

Do doctors have magical powers to see the truth?

- If we did we might see what others don't want us to- so deny our expertise...
- 'MLRs cannot tell who, why or where- therefore they can tell nothing about torture'
- Does the absence of an opposite medical expert in asylum cases lead the decision-maker to form their own clinical judgement?
- Is this why the bar keeps rising for medical evidence?



Asylum law requires a low standard of proof:

- *IP92- ‘The legal standards under which the investigation is conducted are also affected by the context. For example, an investigation culminating in the trial of an alleged perpetrator will require the highest level of proof, whereas a report supporting an application for political asylum in a third country need provide only a relatively low level of proof of torture.’*

An even lower standard:

- ‘a concern they may be a victim of torture’
- for torture survivors not to be routed in to immigration detention
- yet numbers of detained survivors increase despite the supposed safeguards of rule 35- currently under another revision-
- and despite the UN CAT fifth report on the UK concluding observations 2013:



UN CAT fifth report on the UK concluding observations 2013

- Urges the State Party to take necessary measures to ensure vulnerable people and torture survivors are not routed into immigration detention including '*lowering the evidential threshold for torture survivors*'
- not evident in the new template circulating for rule 35 reports...



Myths, legends and their effects

- Caselaw- that is out-dated and clinically wrong
- How the principles of the Istanbul Protocol become subverted by the clinical judgements of non-clinicians
- Research on fabrication assessment and on UKVI decision-making



Body of Evidence 2011

- Demonstrated a lack of consistency in decision making where medical evidence was assessed, both by UKVI and immigration judges
- Risk of critical failure of protection and right to rehabilitation for survivors
- Deficiencies in UKVI handling of cases also highlighted in the report



Progress- First tier Tribunal training

- assessment of expert evidence
- including myth busting that doctors believe everything they are told, who can make psychiatric diagnoses, and the effects of trauma on memory



Progress- a new API on reports from the Foundations

- *Both Foundations are accepted by the Home Office as having **recognised expertise** in the assessment of physical, psychological, psychiatric and social effects of torture*
- *Clinicians and other health care professionals from the Foundations **are objective***
- *MLRs are expert evidence, **not simply a report on the credibility** of a claim of torture*
- *It is not the role of caseworkers to dispute the clinical findings in the report or purport to make **clinical judgements** of their own about medical evidence or medical matters generally*
- *The Protocol, the central importance of which is accepted by the UK courts in the asylum context, makes clear that reports which document and evaluate a claim of torture for asylum proceedings need only provide **'a relatively low level of proof of torture** [or serious harm*
- *Therefore, the Foundations' report in support of the applicant's claim of torture or serious harm **cannot be dismissed or little or no weight attached** to them when the overall assessment of the credibility of the claim is made.*



But...

- Reports are still challenged by decision-makers
- Istanbul Protocol standards are repeatedly questioned
- IP105f- the assessment of possible fabrication- part of medical education 101- *doctors do not believe everything their patients tell them*



Self infliction by proxy allegations

- Predate KV caselaw by several years
- Audit of Sri Lankan heated metal object burns cases indicated as prevalence increased
- HMO burns not new
- BHC letter
- Increasing references in decisions to SIBP- in 'Joseph Camp', in 'Moscow', 'the Balkans', 'East London', 'Croydon'...



Letter quoted in UKBA country of origin information service report 2011

- Second Secretary for Migration at the British High Commission “I asked the Senior Government Intelligence officials if there was any truth in the allegations that the Sri Lankan authorities were torturing suspects. They denied that this was the case and added that *many Sri Lankans who had claimed asylum abroad had inflicted wounds on themselves in order to create scars to support their stories*”

Versions of this allegation occurred in multiple asylum decisions made by UKBA and immigration judges

- 'Immigration judges are aware that determined asylum seekers, seeking to fabricate a claim, may arrange for scars to be inflicted as evidence of injuries received in detention.'
- 'I do not lightly reach the conclusion that this or any appellant has arranged for a third party to injure him in a way such as to produce scarring.... I have however firmly come to the conclusion that this is what the appellant has done.'
- 'the claimant, after losing her case for asylum the first time and being returned to her country "has set out to provide evidence that would enable them to overturn that decision"'
- 'the mere fact of existence of scars does not in itself indicate that the injuries were sustained in the manner you have described or that they were not purposely inflicted in order to fabricate a claim for asylum'.

Audit of 2010-2011 cases

- Assessment of group to identify patterns and trends
- Overall assessment as per IP188 not of single lesion
- Was there evidence of collusion, of a different profile of victim or torture methods?



Secondary gain?

- Leaving poverty and conflict
- Access to jobs, education, healthcare
- How far would you go?



Sri Lankan HMO burns



Fabrication allegation suggests inside knowledge

- Scars assessed as indicating previous combat experience have been accepted as a risk factor for returning Tamils, if the scars are *'readily seen at a checkpoint'*
- *'Put the scars somewhere the person could not have caused them themselves'*
- *'Make them so big no one would believe anyone would consent to the pain and disfigurement'*
- = Ticket to asylum?

But there were no precedents for these conclusions-

- Combat scarring on limbs is not easily confused with burn scars on the back
- No 'minimum number of scars' required for asylum
- Asylum is denied to many torture victims- if it is deemed they are at no future risk- and to patients with HIV, terminal cancer, renal failure



A more rational approach

- 106 medico-legal reports for Sri Lankans 2010-2011
- 31 documented burns from heated metal objects
- What evidence might there be if cases were fabricating evidence of torture?



Compare with previous research on Sri Lankans & others

- 2004 IRCT- 8% HMO burns- in Sri Lanka
- 2007 Perera- 9% HMO burns- in Sri Lanka
- 2011 FFT (unpublished data) 8% HMO burns in Ugandan victims of torture in UK, 4% HMO burns in Iranian victims of torture in UK
- 2010-11 FFT 31% HMO burns in Sri Lankan victims of torture in UK

Methods and sequelae of torture: a study in Sri Lanka. Zoysa P, Fernando R, Torture 2007, 17(1) pp53-56

Physical methods of torture and their sequelae: a Sri Lankan perspective. Perera P. Journal of Forensic and Legal Medicine 14 (2007) 146–150



freedomfromtorture.org

Medical Foundation for the Care of Victims of Torture

Check for possible collusion

- Referring solicitors?
- Last known residence?
- Occupation?
- Place of detention in Sri Lanka?
- Repetition of same story?



Characteristics of fabricated injuries

- Accessible
- Body parts with overlying clothing spared
- Superficial
- Uniform appearance
- Scratches and abrasions common
- Single mode of causation, often sharp pointed implement
- Account of events does not fit clinical findings and timeline
- Absence of defensive injuries
- Symmetry or grouping of lesions



Review of FFT cases thought to be not torture-related

- *Injuries did not match the history given* e.g. traditional medicine scars attributed to torture, dry skin and pigmentation on pressure areas of knees attributed to beating, mature scar attributed to very recent injury
- *Little or no physical and psychological evidence for injuries and experiences described*



Characteristics of torture injuries

- Varying depths and severity
- Varying injury types, often bruising, lacerations
- Varying modes of causation- blunt and sharp trauma, burns from varying heat sources
- No sparing clothed body parts, victim often partly or fully naked
- Congruence between account given, clinical findings and timeline
- Defensive injuries may be absent- but there may be evidence of restraints used
- Symmetry or grouping of injuries



Identifiable factors in SL torture cases

- Complex torture history
- Multiple detentions (41%)
- History and examination findings clinically congruent
- Some scars attributed to non-torture causes indicating lack of exaggeration (77%)
- Other torture scars than burns (90%)
- Sexual assault (56%)
- Psychological impact- 82% PTSD symptoms, 64% already in treatment



Typical case profile

- More than one detention
- Torture includes: suspension, asphyxia with 'petrol bag', sexual assault, cigarette burns, beating with batons, kicks, punches, solitary confinement- and heated metal object burns
- Physical evidence of abrasions from dragging, hyper-pigmentation post-bruising, 11 HMO burns, 33 cigarette burns
- Psychological impact- PTSD symptoms, on medication, self-harming



Cross-checking

- Where one of the above factors was not found, multiple others were present
- same solicitor- burn pattern and torture history differ
- same detention centre- burn pattern and torture history differ
- no other torture scars- but readily attributes 15 scars to non-torture cause, or strong evidence of rape and has PTSD
- no sexual assault but multiple different torture methods, severe PTSD



HMO and cigarette burns

- Principally those with HMO burns accused of fabrication
- Even if both burn injury types on their back, it is the larger HMO burns that are alleged to be fabricated evidence of torture
- But surely cigarette burns easier to do if fabricating torture: no special equipment, less painful, less disfiguring?



KV- the wrong question?

- ‘Can the analysis of a single scar tell us by who or why it was inflicted?’
- No, but analysis of *all* the clinical evidence of an individual can tell us more than one lesion in isolation, and analysis of a group of cases can tell us more still
- IP 188- overall evaluation



Audit summary

- Analysis of 31 Sri Lankan cases finds no evidence of fabrication
- While no one single factor can identify true victim from fabricator, a balanced assessment of all the evidence enables a reasonable likelihood conclusion to be made
- Focussing on a single factor to the exclusion of other evidence distorts decision-making



KV and ‘any lack of congruence?’

- ‘they beat me with iron rods’
- but the lesions found are burns and are curved?
- Consider the contact time required to cause a burn, the pliability of heated metal, and ‘listen to the patient’...



Human skin is not cowhide



Burns are not potato prints



Technical details:

- How long does it take metal to cause a burn that will blister?
- 0.25 sec at 70C *
- How hot is metal if glowing red?
- 480C
- How hot is a domestic wood fire?
- >500C
- Heated steel is very pliable- will act like a whip
- How hot is the tip of a lit cigarette?
- 600C smouldering, >870C with 2 second puff

*BLISTER FORMATION AND TISSUE TEMPERATURE IN RADIANT ENERGY AND CONTACT BURNS *P. R. KuBm, A.B, G. E. SHE[E, M.D, and E. L. ALPEN, Phi). Am J Path 1953 (rat's ears).



Medical Foundation for the Care of Victims of Torture

Audit of response letters requested in 2014-UKVI decision post new API

- 24 cases
- 6 female, 18 male
- Sri Lanka 9, Iran 4, Cameroon 3, DRC 2, Afghanistan, China, Guinea, Pakistan, Russia, Turkey
- 18 general MLR, 2 psychiatric, 4 therapy

Outcome post response letter

- 12 granted asylum 12 refused
- 14 pre-initial decision, 10 fresh claim
- Of initial decision cases, 9 granted, 5 refused
- Of fresh claims, 3 granted 7 refused
- 11 decisions Liverpool, 4 granted, 7 refused



Analysis

- API- *‘Both Foundations are accepted by the Home Office as having recognised expertise in the assessment of physical, psychological, psychiatric and social effects of torture’*
- but 30% of these decisions made negative comments on doctors’ qualifications

100% made negative comments on the MLR methodology or interpretation of findings

- Consideration of alternative causes was at issue in 70%
- Assessment of consistency between findings and account 52%
- **Objectivity of the doctor** 48%
- Use of IP terms 35%
- Consideration of SIBP 13%
- Criticism implied but not explicitly stated 9%
- Other comments include MLR not clear and independent corroboration of account, scars not diagnostic therefore not evidence of torture, not for the doctor to make overall conclusions about how injuries caused (HH), applies 187 meaning of consistent to psych evidence contrary to IP, uses loss of credibility elsewhere to deny the MLR's assessment of likely cause of physical injury



100% made clinical judgements

- Clinical assessment of link between the psychological evidence and torture- 91% =21
- Alternative causation of physical or psychological injuries 70% =16
- Discrepancies in the account 48% =11
- What is likely to be remembered/recall issues 30% =7
- Clinical assessment of link between physical evidence and torture 26% =6
- Reasons not in treatment 17% =4
- Late disclosure 13% =3
- Dating injuries and timeline 13% =3
- How much physical evidence there should be 13% =3
- What is survivable 4% =1
- Accuracy of a diagnosis 4% =1
- Change in prevalence of symptoms over time or with treatment 4% =1



100% made errors in consideration of medical evidence, assessment of credibility and standard of proof

- **Fails to give appropriate level of weight to medical evidence 91% =21**
- Applies negative credibility finding to dismiss medical evidence 78% =18
- **Fails to consider the physical and the psych evidence in relation to torture account 65% =15**
- **Fails to consider the psych evidence in relation to credibility issues 52% =12**
- Misrepresents the MLR evidence in relation to alternative causes 52% =12
- **Cites outdated caselaw 46% =11**
- Misunderstands the IP 39% =9
- Incorrect summary of clinical findings 30% =7
- Draws conclusions based in summary findings without taking detailed findings into account 26% =6
- Fails to explicitly consider clinical findings in relation to the torture account 26% =6
- Misrepresents the MLR findings in relation to the IP 26% =6



2014 decisions

- Repeated and multiple breaches of the API especially use of clinical judgements and failure to give appropriate weight to the MLR
- Citation of outdated and wrong caselaw



HH Ethiopia 2007 EWCA Civ 306

- **‘It was not for the doctor to reach an overall conclusion on the credibility or otherwise of the victim’s account. The most that any doctor could say was the physical and psychological condition of an appellant was consistent with her story’ (para 17)**
- ‘I entirely agree that that is all that a medical report should do, but in fact the doctor in this case at paragraph 19 did purport to go further than that and did purport to pronounce on the credibility of the person’s account which had ben given to her. In my judgement she should not have done so. That is not the function of a medical expert ‘ (para 18)
- ***Confuses credibility assessment and doctor’s obligation to assess fabrication IP105 f***
- ***Confuses use of consistent in non-IP sense and suggests there is no higher level of corroboration of account than this- forgets IP187***



HH problem 2

- ‘Next the appellant criticises the AIT for saying that Dr Hiley **was not a psychiatrist or someone with other specialist psychiatric training** and yet not mentioning that, according to her curriculum vitae, her experience included psychiatry. However all that the AIT was doing was upholding the Immigration Judge’s entitlement to attach little weight to Dr Hiley’s diagnosis of PTSD because of her **lack of specialist psychiatric qualification**. Mr Bazinin says that the judge was wrong to attach little weight to that diagnosis of PTSD and wrong to say that the doctor should have considered other possible causes of the appellant’s depression. I disagree. He was entitled to comment as he did, especially **since the diagnosis was very largely dependent on assuming that the account given by the appellant was to be believed**. I could see no error of law here.’

HH continued

- But the API recognises expertise based on qualifications, training and experience, if report is IP compliant, whether FFT, HBF or independent
- and the FTT training states psychiatric diagnoses can be made by non-psychiatrists and that doctors do not believe everything they are told
- yet the recent case of James Jones (UTJ Frances) refers to requiring specialist training for physical evidence of training that does not in fact exist, and seeks to discard psychological evidence given by a doctor who is not a consultant psychiatrist



AE FE PTSD-Internal relocation) Sri Lanka Starred 2002 UKIAT 05327

- ‘However his expertise and qualification do not necessarily mean that his views must be accepted without question. The LAA is accustomed to receiving reports from psychiatrists which indicate that the asylum seeker in question is suffering from depression or PTSD or both. That there should be a large incidence of PTSD in asylum seekers may not perhaps be altogether surprising, **although we are bound to comment that what used to be considered a relatively rare condition seems to have become remarkably common.**’ (para 8)...**It is hardly surprising that they should suffer at least depression so long as their situation is not settled and there is a real chance that they may be refused entry and returned.**’
- *A clinical judgement about the prevalence and causes of PTSD and conflation of PTSD with depression, that is again without foundation and completely outside the expertise of the non-clinical decision maker*



WT(Adjournment; fresh evidence) Ethiopia (2004) UKIAT 00176

- ‘There is no reason for an adjournment to be granted simply because an appointment has been obtained or has actually been attended with the Medical Foundation. They have a particular expertise, but it is not unique. It cannot be that the existence of a potential Medical Foundation report becomes the basis for successful adjournment applications without very much more to justify the adjournment. An adjudicator would know that **much of what they say consists of a description of physical symptoms which can be provided by others and an assessment that the signs or symptoms are consistent with what the appellant describes.** Consistency is not the same as proof and necessarily **leaves open the point that what is seen is also consistent with some other cause of the injury.**’
- *API- MLR should be regarded as expert evidence*
- *Disregards the IP meaning of consistent with and the expert assessment of levels of consistency according to paragraph 187*
- *Disregards the assessment of relative likelihood that MLR writers now make according to good forensic practice and the caselaw RT, and suggests that a higher level of consistency is required to be substantive evidence of torture, whereas paragraph 161 of the IP reminds us that many forms of torture leave no scars.*



P Yugoslavia 2003

- ‘This case held that consistency does not rule out that scars may have been caused by another method of injury. Furthermore, a medico-legal **report is not proof of when or by whom the injuries may have been sustained neither can they confirm they were as a result of the reasons you have claimed.**’
- *But P Yugoslavia is a psychiatric evidence case about the diagnosis of PTSD and the risk of suicide on return. There is no physical evidence referred to in the text. This has been pasted in from elsewhere but perhaps represents a link to the the concerns that culminated in the accusations of SIBP and the case that is now the caselaw of KV.*



No caselaw cited but often repeated in UKVI decisions:

- A medical report ... cannot normally be regarded as providing by itself a clear and independent corroboration of your account of how these injuries were sustained.'
- *API 'reports are expert and independent'*
- The mere fact of the existence of scars does not, in itself, indicate that the injuries were sustained in the manner you have described.'
- The (medical report) does not state that any of these injuries could be solely attributable to torture or mistreatment which means that they could have been caused by any number of other ways'
- *Wrong standard of proof, diagnostic level not required*
- 1995- a medical report did not establish "in what circumstances these injuries were sustained and by whom any non-accidental injuries might have been inflicted".
- 1999- the secretary of state does not consider that this report confirms how these injuries were received or by whom or adds significant credibility to the claim.'



Abuse of medical evidence 1- 'By whom, where and why'

- use of caselaw to argue the medical evidence has failed to do something and can therefore be discarded, even though that is in any event outside its scope
- MLR cannot tell what colour uniform a guard wore or the name of a prison or the particular motivation of the torturer
- But MLR *can* consider the overall evaluation of physical and psychological evidence as a whole, in the context of what is known of other possible causes of such a clinical picture, and give an expert opinion on likelihood of torture- IP188 and IP287,288

Abuse of medical evidence 2- other possible causes- IP187 and RT

- used to argue other causes can be preferred
- even when the MLR clearly assesses relative likelihood to be in favour of the torture described,
- even though the burden of proof is low so ‘consistent with’ is still significant evidence corroborating an account
- overruling the doctor’s opinion- a clinical judgement they are not qualified to make



Abuse of medical evidence 3- fabrication

- using MLR consideration of IP105 f on fabrication to dismiss the medical evidence on grounds the doctor has considered overall credibility



Abuse of medical evidence 4- 'not a proper expert'

- use of incorrect assertions about medical qualifications, training and expertise to deny medical evidence



Abuse of medical evidence 5- objectivity

- ‘Doctors believe everything they are told’
- Loss of credibility elsewhere in account used to deny the medical evidence recorded by the doctor



Abuse of medical evidence 6- IP187

- use of 'consistent' in 187 sense but for psychological evidence
- use of consistent in dictionary sense when 187 intended, or vice versa
- raising the bar by denying physical evidence if not 'diagnostic' level
- ignores principle of IP161- absence of physical evidence cannot be taken to indicate torture did not occur



How the bar got higher

- Myths in outdated caselaw
- Legends repeated without any citation
- Failure to implement the standards of the new API
- Failure to understand and adhere to the standards of the IP
- Paradoxical expectations of what doctors can and cannot do



IP93

- ‘In countries where asylum-seekers are examined in order to establish evidence of torture, the reluctance to acknowledge claims of trauma and torture may be politically motivated.’



IP272- Counter-transference

- Avoidance, withdrawal and defensive indifference in reaction to being exposed to disturbing material.
- Anger or repugnance against the victim may arise as a result of feeling exposed to unaccustomed levels of anxiety. This also may arise as a result of feeling used by the victim when the clinician experiences doubt about the truth of the alleged torture history and the victim stands to benefit from an evaluation that documents the consequences of the alleged incident



Implications for practise

- Who is an expert in investigation and documentation of torture?
- How should non-IP compliant reports such as rule 35 be assessed?
- Does the disconnect between medical evidence and legal conclusions about it lead to loss of confidence in professional expertise?
- If there is no opposite expert and no cross examination does the decision maker take these roles and are they then led to make clinical judgements in a way that would not happen in other settings?

